PaCT Innovation Hubs

Starter Test Box – Guide for Coaches

The first Share & Learn webinar session with the innovation hub clinics is planned for November 23. Between now and then, teams can work on readiness activities. **As in all PaCT test boxes, teams are not required to do all activities, but we hope that they will consider doing as many as possible.** Several of the activities in this starter test box will provide a foundation for future care planning activities.

Review the activities with the team. If they've already completed any of them, you can check them off. (More in depth descriptions of each activity and how to support the team follows.)

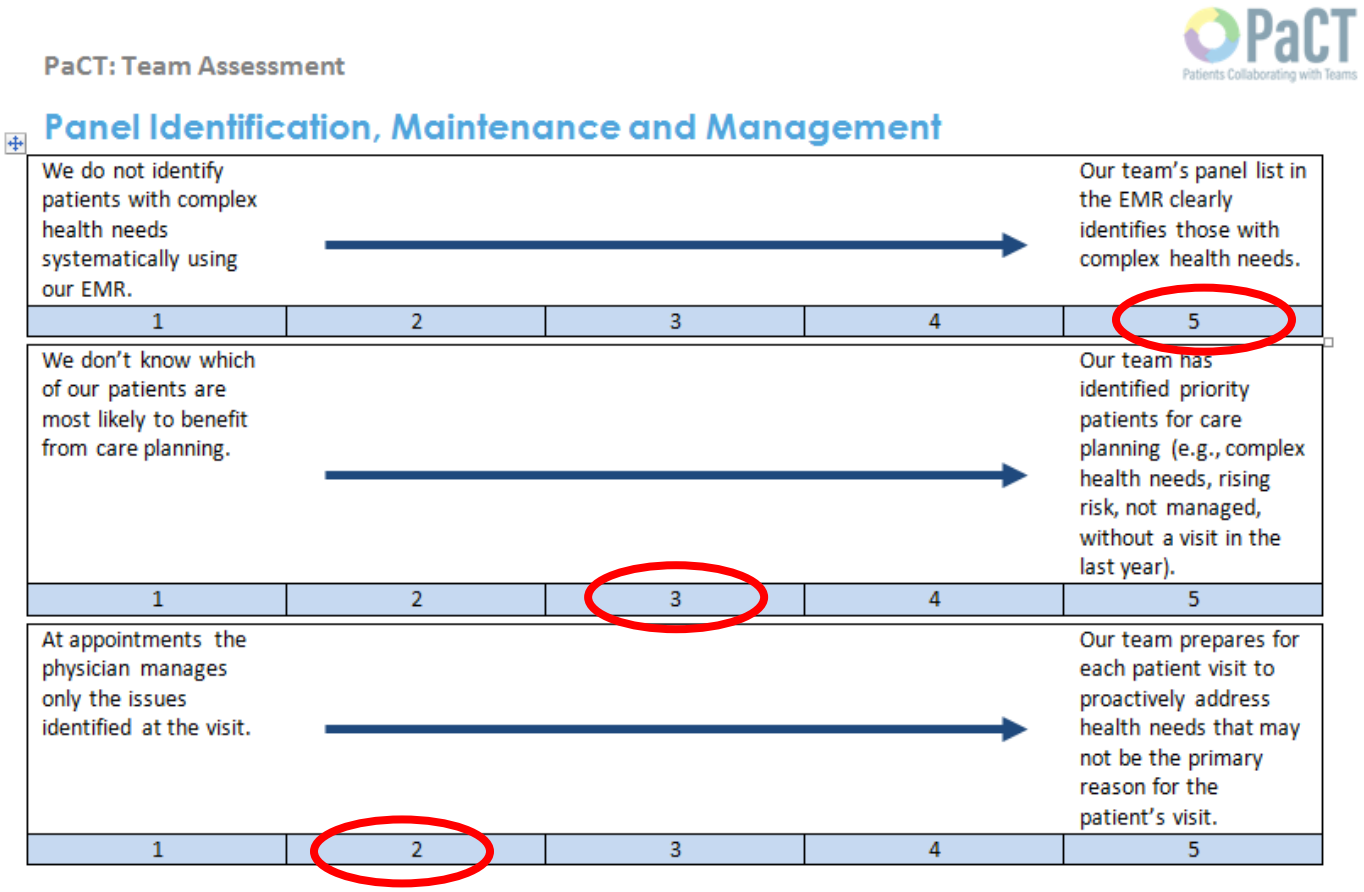
Suggested activities:

Check

- ☐ Team assessment
- ☐ Team meetings
    - ☐ Invite a patient to join the team
    - ☐ When will we meet? How often?
    - ☐ Meeting norms?
    - ☐ Roles in the meetings?
- ☐ Current state process map
- ☐ EMR
    - ☐ Do all team members have access to the EMR?
    - ☐ Discuss and agree upon standard charting procedures for team-based care.
    - ☐ Create a list of patients that meet your care planning criteria and mark the chart of each patient.
    - ☐ Marking the chart in designated field in standard way
    - ☐ Review care plan template, consider adapting and testing.

Team Assessment

- Teams began the assessment at the PaCT Launch event
- Ask team to continue their discussion of each point, and decide as a group, where they currently are on the 5 point scale
- Please record the final scores on a sheet, then scan and email to your AMA TOP Improvement Advisor *(June, Sandee, Sue or Kari)*



PaCT: Team Assessment

PaCT Patients Collaborating with Teams

Panel Identification, Maintenance and Management

We do not identify patients with complex health needs systematically using our EMR. →				Our team's panel list in the EMR clearly identifies those with complex health needs.
1	2	3	4	5
We don't know which of our patients are most likely to benefit from care planning. →				Our team has identified priority patients for care planning (e.g., complex health needs, rising risk, not managed, without a visit in the last year).
1	2	3	4	5
At appointments the physician manages only the issues identified at the visit. →				Our team prepares for each patient visit to proactively address health needs that may not be the primary reason for the patient's visit.
1	2	3	4	5

TIPS

- If teams are stuck, remind them that this is an indicator of their starting point, and for their own reference moving forward
- If deciding between 2 numbers, going with lower number leaves more room for measureable improvement, which can be motivating!

Team meetings

- Invite a patient to join the team
  - Encourage team to be strategic in whom they invite
  - Consider someone who:
    - will speak up and share their honest opinions and insights
    - has a positive nature
    - can be available for team meetings
    - has experienced (or supported family member) through the care planning process previously

  NOTE: Consider reviewing the document handed out at the PaCT Launch, entitled 'Ideas to Support Patient Representatives'

- When will we meet? How often?
  - Encourage teams to commit to meeting at least every two weeks to keep up momentum
  - Set a location, regular day of the week and time
  - Does the space need to be formally booked? Consider all logistics

- Meeting norms
  - What do team members consider important for their meetings? Brainstorm.
    - *e.g., start & end on time, no cell phones, everyone is heard, etc.*
  - Record norms on flipchart paper and put up at meetings
  - Refer back to as necessary

- Roles in the meetings
  - What roles would the team like to have for the meetings?
    - *e.g., chair, timer, action items recorder, etc.*
  - Will the roles be set or rotate?
  - Who will be responsible for setting the agenda?
  - How will the action items be communicated?
  - Who is recording the team's results, thoughts and ideas for the Share & Learn webinars?

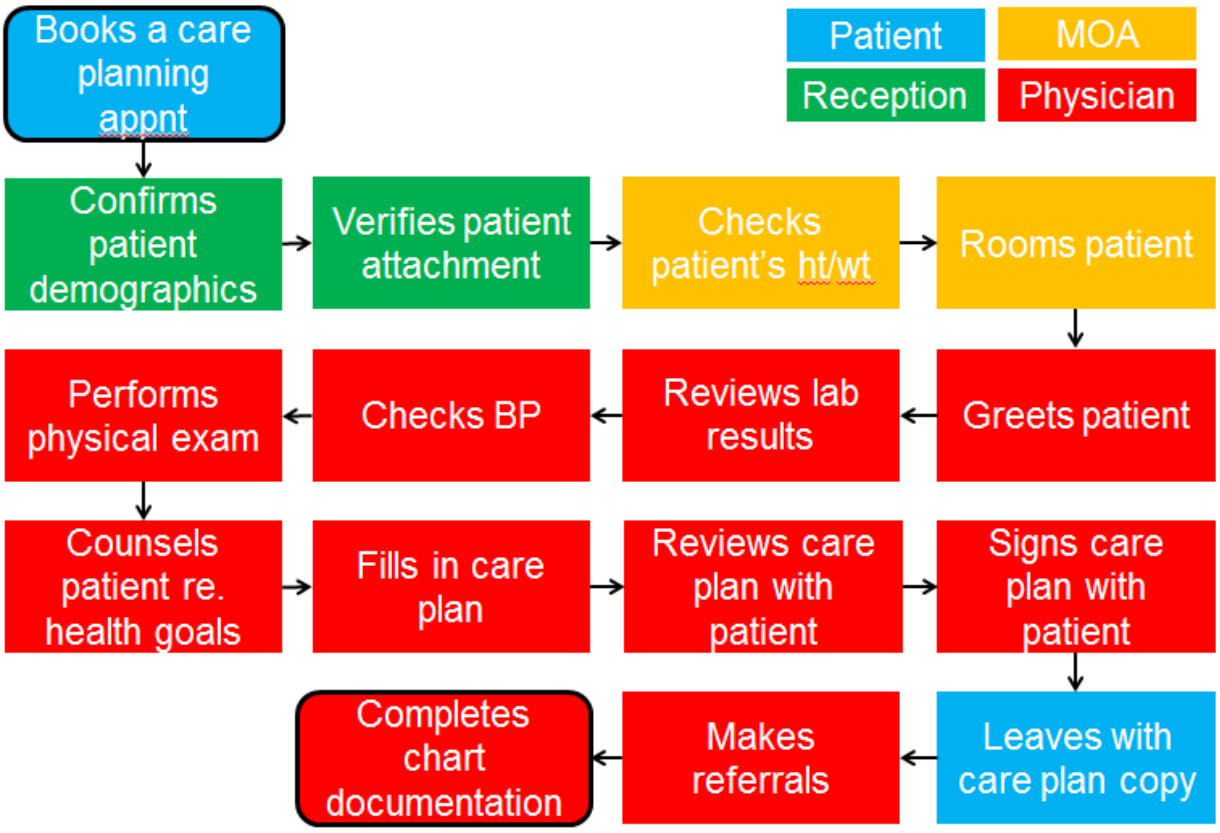
Current State Process Map

- With representation from all areas of the clinic who have any part of care planning (including a patient, if possible), lead team to process map their current care planning process using post-it notes
- Once the map is complete, it will be used for activities in future Test Boxes, for example:
  - At what point do conversations with the patient occur where scripting may be beneficial?
  - Which tasks does the physician currently do that could be handled by another team member?

TIPS

- Begin by naming the process, and identifying the 'start' and 'finish'
- Brainstorm the actions between
- All actions start with a verb (e.g., opens chart, gives to patient)
- Consider using a different colour post-it note for each role involved in process
- When finalized, use PowerPoint or Visio or other program to document for future reference, OR
- Tape the post-it notes to a large sheet of paper, and bring to subsequent meetings

EXAMPLE



EMR

- Do all team members have access to the EMR?
  - A goal of PaCT is to optimize use of the team in care planning
  - It will be important that all involved team members have access to patient charts in the EMR
  - Identify if that is currently the case, and if not, ask how arrangements can be made to get access for those team members
  - Ensure this is recorded as an action item, and work with the group to set a reasonable time frame for completion

- Discuss and agree upon standard charting procedures for team-based care
  - Moving forward, it will be important that there is standardization around where and how information related to care planning is charted in the EMR
  - This will likely be an ongoing discussion, but it's good to plant the seed and discuss what can be standardized now

- Create a list of patients that meet your care planning criteria and mark the chart of each patient
  - Teams will likely have already selected the group of patients that they would like to start with
  - If not, remember the general criteria is patients with:
    - *Complex health needs*
    - *Rising risk*
    - *Not managed*
    - *Haven't been seen in more than 1 year*

Creating Patient Lists

There are 3 steps for your team to complete to create the list of patients who you will ultimately offer care planning to:

- Creating and running the EMR search for patients who have the 'complexity' criteria you have selected
- As a team, reviewing the list generated from the EMR to validate who will be offered care planning
- Marking the patient's chart to indicate they have 'complex health needs'

Creating and running EMR Searches for complex patients

Depending on what complexity criteria your clinic has selected, this may be an easy step or require EMR clean up and/or new EMR processes.

For instance, if your clinic chooses to search for patients who have had 3 or more ER visits in the last year and this is already noted consistently in a searchable field within your EMR, then the only work in this step is to create and run the search.

If your clinic chooses to search for patients with 3 or more chronic conditions but the problem list is not consistently coded, or perhaps not used at all, then some initial work may be required to clean up and/or populate a coded problem list.

The TOP 'EMR Guide to the Patient's Medical Home' includes sections on charting for team based care (page 17). Each EMR specific guide includes considerations for charting, as well as descriptions and screen shots of suggested searches.

http://www.topalbertadoctors.org/file/guiding-principles--effective-use-of-emr-for-pmh-work.pdf

Review the List Generated from the EMR

As a team, review the list that has been generated from the EMR. First, you want to be sure that the list is accurate. With many of the team members viewing it, they may find patients on the list who have complex health needs and some that do not. This is a good opportunity to verify and discuss your EMR processes.

The second and more important reason to review the list is to verify that the clinic team would like to offer the patients on the list a care planning opportunity. There may be patients on the list who fit the criteria you have selected, but for some reason they should not be offered care planning.

This process may be accomplished in a team meeting, or you may find another way to communicate about this. The important thing is that the appropriate team member knows who to identify for care planning.

Mark the appropriate charts "complex health needs"

Once you have confirmed which patients you would like to offer care planning to, you'll want to indicate this in a searchable field in the EMR. We have used the example of "complex health needs" but a standard word, phrase, or even checkbox if your EMR has one, can be used. The key is that you can use your EMR to search for these patients.

The EMR specific guides have suggestion(s) on how this can be done for each EMR as the processes differ for each.

Review care plan template, consider adapting and testing

An optional care plan template for PaCT was introduced at the Launch session. Invite your team to review the new template and consider which aspects they may be interested in testing and/or adapting their current care plan to reflect. Remind the teams that we're hoping to get feedback from them on the template – Is it helpful? Are there aspects that are missing? How can we make it better?